Medicaid Information Bulletin

July 2001

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This bulletin is available in editions for people with disabilities.
Call Medicaid Information: 538-6155
or toll free 1-800-662-9651.

World Wide Web: www.health.state.ut.us/medicaid

Medicaid Information

- Salt Lake City area, call 538-6155.
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.
- From other states, call 1-801-538-6155.

Requesting a Medicaid publication?

Send a Publication Request Form.

- by FAX: 1-801-536-0476
- by mail to: Division Of Health Care Financing Box 143106, Salt Lake City UT 84114-3106

01 - 54 Medicaid Budget Hearing for Fiscal Year 2002

The Department of Health invites you to a special Medical Care Advisory Committee (MCAC) meeting to obtain public input on the Medicaid and UMAP (Utah Medial Assistance Program) budgets for Fiscal Year 2002. The meeting will be held Thursday, July 19, 2001 from 4:00 p.m. until 6:00 p.m. at the Cannon Health Building, 288 North 1460 West, in Room 114.

Note: The Cannon Health Building is a secured building. Access Room 114 directly by entering the **east** entrance by the Health Clinic and Day Care. If you use the main entrance on the south side of the building, you must obtain a visitor's pass and be escorted to room 114.

Fiscal Year 2002 is July 1, 2001 through June 30, 2002. The MCAC is an advisory group which recommends funding and program directions to the Department of Health and the Governor.

If you know of special medical needs not being met by the Medicaid or UMAP programs, or want to speak on a budgetary matter of importance to you, please come prepared to make a short (no more than five minutes) presentation to the Committee. Copy services will be provided if you have a handout. SIGNED PETITIONS ARE ENCOURAGED. Your input will assist the MCAC in recommending a budget that will be more representative of Medicaid and UMAP providers and clients.

If you cannot attend the public hearing, but would like to write to the MCAC Committee about special medical needs, please mail your comments by Monday, July 02, 2001, to:

MCAC Committee
Division of Health Care Financing
Box 143103
Salt Lake City, UT 84114-3103

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01 - 55 Medicaid Provider Training

Statewide provider training is tentatively scheduled for August through September 2001. Sessions include an overview of Medicaid, general billing tips and policy updates. If you have a particular topic or question you would like to be discussed in the sessions, please contact the Training and Special Projects Unit by FAX at (801) 536-0976 or by phone. Call Medicaid Information; ask for the Training Unit. Specific dates and session locations will be announced in a separate mailer and on the Medicaid web site at www.health.state.ut.us/medicaid/html/what_s_new.html

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01 - 56 Standards for Claim Submission; Billing Third Party Liability

Medicaid requires providers to submit a quality claim form. A quality claim is either a submission of an electronic claim or a paper claim which is on the appropriate form, legible, on line and with valid information in the appropriate boxes. Incorrect, inappropriate, or illegible forms will be returned for resubmission. Faxed, copied or e-mailed claims may not meet the standards of a quality claim.

If you are mailing paper claims to Medicaid, please ensure that you are using the correct mailing address.

Bureau of Medicaid Operations
Box 143106
Salt Lake City, UT 84114-3106

For faster processing of claims, accuracy and timely response of claim status, we recommend electronic billing. For more information,

- Hospital and professional providers, contact UHIN (Utah Health Information Network) at (801) 466-7705.
- Dental providers, contact Medicaid Operations and Development staff at (801) 538-6155 (or toll-free 1-800-662-9651), option 3, then 5.
- Pharmacy providers, contact Envoy Corporation at 1-800-333-6869 or National Data Corporation (NDC) at 1-800-388-2316.

SECTION 1 has been updated to add information on a quality claim to Chapter 11-9, Billing Medicaid.

FOR FASTER PAYMENT WHEN A CLAIM HAS TPL (**t**hird **p**arty **l**iability coverage other than Medicaid), double check these instructions:

1. TPL pays. Enter the TPL amount in the correct box on the claim, according to billing instructions. An EOB is NOT required. A common mistake is to leave the TPL box blank and attach an EOB instead. A Medicaid claim with TPL will suspend if the TPL box is left blank.

2. TPL pays zero. Send the EOB with the claim. A common mistake is failing to attach the EOB to show TPL paid zero.

3. Resubmitting a claim. If you submit a claim electronically, you can resubmit electronically. Resubmitting a paper claim slows processing of your claim.

For more information, refer to SECTION 1, Chapter 11-4. Billing Third Parties, and Chapter 11-11, Rebill Denied Claims with Corrected Information.

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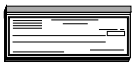
01 - 57 Reporting Medicaid Overpayments; Payment Adjustment Request Form Instructions

There are two ways to report an overpayment to Medicaid and refund the amount overpaid. You can either call Medicaid Information or mail a check to the Office of Recovery Services.

- ☞ Do not call Medicaid and also mail a check to Recovery Services, or the overpayment may be taken back twice!
- ☞ These instructions apply only to fee-for-service payments. They do not apply to payments received from a managed care plan. The last paragraph of this article has information on overpayments from managed care plans.

1. CALL MEDICAID INFORMATION
   Call to have the claim adjusted to the correct payment. The overpayment will be taken from future payments. (This is what Medicaid staff do when they identify an overpayment.)

OR



2. MAIL A CHECK TO OFFICE OF RECOVERY SERVICES (ORS)
   A. Make a check payable to Medicaid for the amount of the overpayment.
   B. Enclose either a Payment Adjustment Request form or a copy of the remittance statement with a circle around the TCN number of the claim you want to correct. You can get a copy of the Payment Adjustment Request Form from the Internet, www.health.state.ut.us/medicaid/PAR.pdf, or from the General Attachments section of the Utah Medicaid Provider Manual.
   C. Write the reason for the overpayment on the remittance statement or Payment Adjustment Request. Possible reasons include third party payment, duplicate payment, or credit balance (if there was a CR on your remittance statement).
   D. Mail the check and form to:
      Office of Recovery Services
      Medicaid Section, Team 85
      P. O. Box 45025
      Salt Lake City, Utah 84145

Instructions for Payment Adjustment Request Form

The instructions for reporting an overpayment have been added to the Payment Adjustment Request form instructions. A copy is available on the Internet: www.health.state.ut.us/medicaid/PAR.pdf.

Managed Care Plans: Each managed health care plan (HMO or mental health plan) has a process to recover overpayments. Contact the individual plan for instructions about refunding an overpayment to a managed care plan. ☐

01 - 58 Medicaid Implementing HIPAA Standards

The Administrative Simplification provisions of HIPAA (Health Insurance Portability and Accountability Act of 1996) mandate that standards be adopted for all health care information that is electronically exchanged. On August 17, 2000, the final rule for national standards for electronic transactions was published in the Federal Register. The rule adopts standards for eight electronic transactions which include:

- Health Care Claims or Equivalent Encounter Information
- Eligibility for a Health Plan
- Referral Certification and Authorization
- Health Care Claim Status
- Enrollment and Dis-enrollment in a Health Plan
- Health Care Payment and Remittance Advice
- Health Plan Premium Payments
- Coordination of Benefits

Medicaid is currently modifying computer systems to support these standards. We will stagger the implementation of the standards with the goal of being in compliance by October 16, 2002. At that time, all providers who submit claims electronically will be required to use the HIPAA standards. We will notify providers as each transaction is implemented by Medicaid.

Providers who submit paper claims may also notice some process changes due to Medicaid's implementation of the electronic standards. All providers are encouraged to perform their office processes electronically. Utilization of the electronic HIPAA transactions for claims submission, remittance advice, claim status, eligibility inquiry, etc., should significantly reduce a provider's operating costs, reduce response time and improve the quality of data transferred between the provider and health plans.

The insurance commissioner, the standards authority, releases its information via the UHIN web site at www.UHIN.com. ☐

01 - 59 Medicaid Announces the Results of Two Child Health Measures

State Medicaid programs are required to report on the percentage of children who receive well-child (CHEC) visits. The report format is known as the HCFA-416. The results reported this year show an increase in the percentage of children receiving well child (CHEC) visits, an increase in the number of children receiving preventive dental services and an increase in the number of children who are appropriately tested for blood lead level. The federal target level for the overall participation level is 80%. Utah reported the following for federal fiscal year 2000:

Age group ➜	Total	< 1	1-2	3 -5	6 -9	10 -14	15-18	19 -21
# of children	129,733↘	24,350↗	22,237↗	23,469↗	20,637↘	19,269↘	13,217↘	6,554↘
Participation Ratio	87%↗	87%↗	67%↗	78%↗	100%→	100%↗	100%→	100%→
# of children referred for follow-up treatment	96↘	5↘	20↘	33↘	18↘	15↘	5↘	0→
Children who received preventive dental services	8,593↗	11↗	517→	2,276↗	2,629↗	2,189↗	863↗	108↗
Children receiving blood lead level tests	342↗	137↗	148↗	57↗				

- The arrows indicate an increase, decrease or no change from last year.
- The number of children is an unduplicated count of all children enrolled in Medicaid during the reporting period.
- The 'Participation Ratio' is the percent of children who received at least one well-child (CHEC) visit during the time period. The ratio does not mean that children received all visits recommended on the periodicity schedule.
- The number of children referred for follow-up treatment from one of those well-child (CHEC) visits is very low. We believe that health care providers do refer children for follow-up based on what they find during the well-child visit, but do not inform us. Please remember to use the CF modifier with the CPT4 well-child code when submitting claims.
- The number of children who receive preventive dental services is low. We encourage families to take children to the dentist for preventive care twice a year. Please help us by reminding parents of the importance of oral health.
- The number of children who receive blood lead level tests is also very low. Children ages 0 to 72 months should have a verbal assessment of their risk for exposure to lead. Children at high risk and those who are 12 to 24 months should have a blood lead level test.

Please refer to the Utah Medicaid Provider Manual for CHEC Services for guidelines on well-child (CHEC) visits. The manual is on the Internet at: www.health.state.ut.us/medicaid/html/chec_services_manual.html

Utah is one of seventeen states participating in the Health Care Financing Administration's Government Program and Results Act (GPRA) Immunization Measure. This is a four-year project, though Utah Medicaid intends to make this a regular report. All fifty states will, eventually, measure the percent of two-year-old children enrolled in Medicaid who are fully immunized. The state may determine the measurement methodology and define fully immunized. The Immunization Program in the Division of Community and Family Health Maternal and Child Health Bureau has been an active partner in this measure.

We chose to define 'fully immunized' as 4 DtaP, 3 Polio, 1 MMR, 3 Hep B, and 3 Hib. We selected a sample of 400 children who turned two during the base line year and who had been enrolled in Medicaid for at least six continuous months. We looked at records from our MMIS claims system and the Utah Immunization Information System (USIIS). We received more complete data from these sources this year.

The information collected was input to a CASA program. For federal fiscal year 1999, we could identify only 19% of the children in our sample as fully immunized. For federal fiscal year 2000, we identified that 27.75% of all children in our sample were fully immunized. We appreciate providers who helped us collect this information, as we continue to have problems with incomplete data sets.

This is the first year states were required to report on dental participation. Unfortunately, our dental participation for any service is low. We calculate that only 7% of children received preventive dental services. Only 41% of children received any dental services.

For more information on either of these child health measures, contact Julie Olson at 801-538-6303 or by e-mail at jolson@doh.state.ut.us. ☐

01 - 60 Immunization Schedule for 2001

The Recommended Childhood Immunization Schedule for 2001 is now available on the Internet at www.health.state.ut.us/medicaid/chec2.pdf. Pneumococcal Conjugate has been added. The schedule is in two Utah Medicaid Provider Manuals: Physician Services and Child Health Evaluation and Care Program (CHEC) Services.

If you do not have access to the schedule on the Internet, contact Medicaid Information for a copy of the Immunization Schedule for 2001. ☐

01 - 61 Foster Care Children, Medical Eligibility: Form MI-706

Effective July 2001, the State Medical Services (MI-706) form will be prepared by eligibility workers working for the Department of Human Services. The nurses working for the Utah Department of Health's Fostering Healthy Children program no longer issue these forms except to authorize a specific medical service(s) prior to services being given.

The form is used by Medicaid to process claims for services given to children in Foster Care, even when the child is not eligible for Medicaid, or until Medicaid can be approved by the Department of Human Services. The form (MI-706) is the same reimbursement agreement form used by the Utah Medical Assistance Program. However, when the form is authorized for a child, the claim is processed and reimbursed as if it were a Medicaid claim by preparing your claim form and including the form's prior authorization number.

If you have a question or comment, contact the child's caseworker or call Julie Thomas at (801) 538-6085, or toll-free at 1-800-662-9651 and enter #210. Julie can help you submit your claim or direct you to the caseworker for further information. ☐

01 - 62 Shaken Baby Prevention Project

Effective September 1, 2001, Medicaid will support the Shaken Baby Syndrome Prevention Project by increasing the DRG payment for a delivery by $6.00. The additional $6.00 per delivery will be paid for children born to mothers enrolled in Medicaid, including HMOs. The money is to cover the costs for educating new parents about Shaken Baby Syndrome.

The project will provide information about the physical effects and harm of shaking a baby to new parents before the mother is discharged from the hospital. Information includes a video tape, written materials and face-to-face education. Parents will be asked to sign a pledge not to shake the baby. Hospital staff may present the information, or a hospital may choose to subcontract with the National Center on Shaken Baby Syndrome in Ogden. The center has a curriculum for this education.

The Utah Department of Health and the National Center on Shaken Baby Syndrome are designing a follow-up process to ensure that new parents receive the information. For more information on the project, contact Debbie Williams at the National Center, 1- 888-273-0071.
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01 - 63 Utah Medicaid Provider Manual for Physician Services Now Available on the Internet

The Utah Medicaid Provider Manual for Physician Services is now available on the Internet. This manual has four sections:

- SECTION 1, General Information, (for all providers) www.health.state.ut.us/medicaid/SECTION1.pdf
- SECTION 2, Physician Services
- SECTION 3, Anesthesiology Services
- SECTION 4, Lab Services

The Table of Contents for SECTIONS 2, 3, and 4 is at www.health.state.ut.us/medicaid/phystoc.pdf. Providers can also access the electronic manual through the Medicaid Provider Guide web site www.health.state.ut.us/medicaid/html/provider.html. On the Provider Guide page, select the link to SECTION 2. Then choose either the link to the list of SECTION 2 policies in either Adobe Acrobat Reader or a text version. Either list will point the user to an Acrobat Reader version of the Physician Services Manual. Since the software Acrobat Reader is required to access the Physician Manual, there is also a link for information and free installation of this software. ☐

01 - 64 Heart Transplant Criteria: Ventricular Assist Devices

Ventricular Assist Devices may be prior approved by telephone for clients who have been preauthorized for heart transplantation. This is to ensure compliance with FDA guidelines for critically ill patients. This policy change is added to Criteria #28, which describes the conditions of coverage for heart transplantation, as a new item C. To update the criteria, refer to the bulletin titled "Criteria for Surgical Procedures Now a Separate List."

Codes for Ventricular Assist Devices

CPT codes

33975 implantation single ventricle support device
33977 removal single ventricle support device
33976 implantation biventricular support device
33978 removal biventricular support device

ICD-9 Codes

37.62 Implant of other heart assist system
37.63 Replacement or repair of heart assist system
37.64 Removal of heart assist system
37.66 Implantation of pulsatile heart assist system

Hospital and Physician Manuals Updated

The CPT and ICD-9 codes have been added to lists in two manuals:
– Physicians, Medical and Surgical Procedures List.
– Hospitals, Surgical Procedures Code List.
Providers will find attached the corrected pages to update the code lists. Codes newly added to each list are in bold print. ☐

01 - 65 Physician Manual Updates: Maternity Care Clarifications; Use of Modifier 25

Maternity Care Clarifications

The following statements regarding maternity care are clarified in SECTION 2 of the Utah Medicaid Provider Manual for Physician Services. Words in **bold print** are new.

Chapter 2, COVERED SERVICES, item 32 Maternity Care (page 14):

A. Antepartum Care

The initial **office** visit to a physician is not a separate billable service. It must be included as part of the global maternity service. **Special** laboratory work at the time of the initial visit is an exception, but must be billed by the laboratory completing the tests and not by the physician.

Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressure, fetal heart tones, routine chemical **urinalysis**, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery.

D. Complications

Another example, **pre-term labor**, is added to the last line, between "systemic implications" and "drug dependence."

E. High Risk Pregnancy, sub-item 2, Other Services (page 15)

The second paragraph changed as follows: "Fetal Non-stress Test (code 59025) will be covered only for **clinically documented** high-risk pregnancy. Use of this test **is considered appropriate for, but not limited to, patients who** have hypertension, diabetes, **other systemic diseases,** a history of previous stillbirth, or when there is a decrease or absence of fetal movement.

Indications, repetition, frequency and utilization of the fetal non-stress test will be evaluated through documentation in the record of any pregnancy case being reviewed."

Use of Modifier 25

Chapter 3, LIMITATIONS, item D 1 (page 17) is revised as follows. (Words in bold print are new.)

1. Modifier 25 will not be recognized **as a stand alone entity to override the one service per day Medicaid policy**. If a significant, separately identifiable E/M service **or another service** is necessary on the same day by the same provider, rather than using modifier 25, the service can be identified with its own unique ICD.9.CM diagnosis code and be appropriately documented in the medical record. **The claim will deny because of the two services on one day. Documentation may be submitted for review to verify the service. Significant, separately identifiable E/M service will be the emphasis of the review to determine if both services are appropriate for payment.**

Physician Manual Updated

Providers of physician services will find attached the pages to update their manual. A vertical line is placed in the margin to mark where text has changed. ☐

01 - 66 Criteria for Medical and Surgical Procedures Now a Separate List

To minimize duplication of the criteria for medical and surgical procedures in provider manuals, the criteria will be maintained as a separate document. A copy of the new document, updated to July 2001, is attached for physicians and hospitals.

Updating the Medical and Surgical Procedures List

The Medical and Surgical Procedures List (CPT codes) is a special attachment to the Utah Medicaid Provider Manual for Physician Services. Discard pages 61 - 82. The new list Criteria for Medical and Surgical Procedures has current information in place of the pages discarded.

Updating the Surgical Procedures Code List

The Surgical Procedures Code List (ICD-9 codes) is a special attachment to two Utah Medicaid Provider Manuals: Physician Services and Hospital Services. Discard pages 15 - 30 from the ICD-9 list. You can keep the Index on pages 31-32. When the ICD-9 list is reprinted, the index will be renumbered as pages 15-16. The new list Criteria for Medical and Surgical Procedures has current information in place of the pages discarded. ☐

01 - 67 Sterilization Consent: Criteria #10 and Instructions for Form 499-A Updated

Criteria #10 (Sterilization/Other Genito-urinary Procedures) and the instructions for Form 499-A have been updated. A new criterion, item C, is added to Criteria #10: "C. For a client who is pregnant, the consent must be signed at least 30 days before the expected delivery date. This is true even in the case of the emergency exception noted in item (2) under the heading 'Physician's Statement'." With this addition, the current items C, D and E are renumbered as D, E, and F.

A missing phrase is restored to newly renumbered item E. The phrase is in bold print: "E. Procedure must be performed no sooner than 30 days after the client signs the consent and no longer than 180 days, unless it meets the requirements of the Medicaid Sterilization Consent Form (Form 499-A), in item (2) **under the heading PHYSICIAN'S STATEMENT**."

The revised Criteria #10 is in the July 2001 Criteria for Medical and Surgical Procedures attached for providers of physician services and hospital services. A copy of Form 499-A and instructions are available on the Internet www.health.state.ut.us/medicaid/499a.pdf . ☐

01 - 68 Transplant Criteria: References to Age Removed

As a reminder, transplantation services may be provided for a Medicaid eligible client of any age who meets the criteria. Age is not a determining factor in review and approval of any organ or tissue transplantation request. Decisions are made based on compliance with criteria for the specific transplant request.

All references to age are removed from Transplant Criteria 24 through 28 which appear in two code lists: the Medical and Surgical Procedures List in the Utah Medicaid Provider Manual for Physician Services and the Surgical Procedures Code List in the Utah Medicaid Provider Manual for Hospital Services. To clarify policy, criteria now state, "Transplantation services may be provided for a Medicaid eligible client of any age who meets the criteria."

To update these lists, refer to the preceding bulletin titled "Criteria for Surgical Procedures Now a Separate List." ☐

01 - 69 Medicaid Provider Agreement: Deadline Suspended

At this time, Medicaid will allow providers to continue enrollment under their original agreement or re-enroll under the new agreement issued in January 2001. Medicaid will not enforce the previously announced deadline of June 1 for returning a signed, new agreement.

Additional comments on the January agreement have been received from the Utah Medical Association and attorneys in the Department of Health. Until all concerns can be addressed, providers with a valid Medicaid agreement may continue enrollment. We will advise you when a new Provider Agreement will be available.

We appreciate the interest in the agreement and your patience and support. If you have questions, you may call Provider Enrollment (801) 538-6155 or toll-free 1-800-662-9651. Select menu option 3, then menu option 4. ☐

01 - 70 Prescribers and Pharmacists: Over-the-Counter Drug List Updated. Products with phenxlpropapolamine (PPA) Not Covered; Six Products Added

The Over-the-Counter (OTC) Drug List has been updated. Prescribers and pharmacists will find the list attached. The list is also available on the Internet at www.health.state.ut.us/medicaid/otclist.pdf .

- Products with phenxlpropapolamine (PPA) are not covered. Product removed from the list is Tavist-D. The manufacturer of Triaminic reformulated the product so it no longer contains PPA. Medicaid will continue to cover the Triaminic line and generic equivalent.
- Products added are Benadryl Allergy Decongestant, Drixoral syrup, ferrous gluconate, Pediacare Cough-Cold, Pedia Relief Cough & Cold, Senokot.

Refer to the list for criteria on coverage. A vertical line in the left margin marks additions or changes. An asterisk (*) in the margin marks where text was deleted. ☐

01 - 71 Prescribers and Pharmacists, Drug Criteria & Limits List Corrections: Amphetamines; 5-HT3 Receptor Antagonists, Zofran® (ondansetron HCL), Anzemet® (dolasetron mesylate), Kytril®; Enbrel; Oseltamivir phosphate (Tamiflu7); Lovenox

The criteria for drugs listed below have been corrected on the Drug Criteria & Limits List. For complete information, refer to the replacement pages attached dated July 2001.

- Amphetamines, length of prior approval extended (page 8)
- 5-HT3 Receptor Antagonists, Zofran® (ondansetron HCL), Anzemet® (dolasetron mesylate), Kytril® (ondansetron HCL), drugs added and criteria clarified. (page 14)
- Enbrel, diagnosis corrected (page 15). The correct diagnosis is "moderate to severe rheumatoid arthritis."
- Oseltamivir phosphate (Tamiflu7), use as prophylaxis added and the criteria for coverage. (page 25)
- Lovenox, diagnoses and criteria clarified. (pages 28-29)

The Drug Criteria and Limits List is a special attachment for the Utah Medicaid Provider Manuals for Physician Services and for Pharmacy Services. ☐

01 - 72 Pharmacists: Utah MAC Updated

Effective March 9, 2001, the Utah MAC list was updated. There are two MAC lists: the federal MAC and the state MAC. Select drugs, and some drugs as a class such as prenatal vitamins, are on the state MAC. The Utah MAC list programmed in 1991 referenced generic manufacturers, most of which are no longer in business. The new program does not reference manufacturers by name. It is much more extensive and allows products deleted from the Federal MAC to be moved to the Utah MAC.

All programs carry the risk that some prices are simply not attainable. The Medicaid program managers make every effort to correct prices based on current invoiced costs. Pharmacies are encouraged to contact RaeDell Ashley or Duane Parke at (801) 538-6149 for price corrections. ☐

01 - 73 Pharmacy Manual Updated

SECTION 2 of the Utah Medicaid Provider Manual for Pharmacy Services has been updated. Providers will find the July 2001 version attached. A page which states "Page updated July 2001" on the upper right has a new correction or clarification. A vertical line in the left margin marks where text has changed. An asterisk (*) in the margin marks where text was deleted. This revision of SECTION 2 can be found on the World Wide Web through a link at:

www.health.state.ut.us/medicaid/html/section_2.htm

The Internet copy formerly at www.health.state.ut.us/medicaid/html/pharmacy_manual.htm has been removed as it is now outdated. ☐

01 - 74 Code Added for Standard Wheel Chair

Code K0001LR, standard wheelchair (no attachments), is added to the Medical Supplies List, page 39. Rental is by month. The updated page is attached for medical suppliers and physicians. ☐

01 - 75 Multiple Dispensing Fees Associated with Home Infusion Pharmacy Services

Due to a directive from the U.S. Department of Justice (DOJ), effective August 1, 2001, there will be multiple dispensing fees associated with home infusion pharmacy services. The DOJ, as part of a legal process, established a "true AWP" for 437 NDC specific products. The "true AWP" is close to actual acquisition costs. To implement this change in dispensing fees, the Division of Health Care Financing established an Infusion Committee with representatives of the home I.V. infusion specialty pharmacies. The group placed each of the 437 NDCs in one of five categories, according to difficulty of preparation and overhead costs.

Categories range from one through five. Category one is for services deemed to be the same as those prescriptions normally filled at a typical retail pharmacy. Category five is the most difficult and expensive services to prepare.

- Category two includes nebulizer preparations, growth hormone, etc.
- Category three includes simple I.V. antibiotics, anticoagulant treatments, I.V. gamma globulin, etc.
- Category four includes complex antibiotics that require laboratory monitoring and reporting.
- Category five includes chemotherapy I.V.s, pain management, and cardiac ionotropics. For example, chemotherapy requires a separate vertical hood and complete gowning to meet OSHA standards, which adds considerable expense of time and set-up costs.

Categories two through five will have a new dispensing fee effective August 1, 2001.

Category 2	$ 8.90
Category 3	$ 18.90
Category 4	$ 22.90
Category 5	$ 33.90

The 437 NDCs identified by the DOJ will be linked to their counterparts for other manufacturers. Other brands will be reimbursed at the same rate as the DOJ's 437 NDCs. All pharmacies will be reimbursed at the same rate for these NDCs.

This information is added to SECTION 2 of the Utah Medicaid Provider Manual for Pharmacy Services as a new chapter 4 - 11, Multiple Dispensing Fees Associated with Home Infusion Pharmacy Services. ☐

01 - 76 Metabolic Nutritional Supplements

Nutrients and metabolics are available through the Medical Supplies program. SECTION 2 of the Utah Medicaid Provider Manual for Medical Suppliers is updated in regard to coverage of metabolic nutritional supplements. Enteral and metabolic nutrients requested by WIC require a written prior authorization. A telephone request may be made for all other prescriptions.

Chapter 2 - 2, Parenteral and Enteral Nutrition Therapy, item F, Service Coverage, (page 11) sub-item c is corrected and a new sub-item d is added. The last sub-item is renumbered to "e." A new item G, Metabolic Nutritional Supplements, is added to page 12. The corrected pages are attached. A vertical line is placed in the margin to mark where text which has been changed or added.

Medical Supplies List Updated

Five groups of products have been added to the Medical Supplies List in the category NUTRIENTS: Mead Johnson Products, SHS Products, Food Tek (Phenylade) Products, MTE Products, Ross Products and miscellaneous. They require written prior authorization. The new items are added to page 13 between enteral and parenteral formulae. The updated pages 12 through 14 are attached. Codes newly added are in **bold print**.

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01 - 77 DRG Payment Methodology for Urban Hospitals

As announced in bulletin 01 - 36, DRG Payment Methodology for Urban Hospitals, published in April 2001, Utah Medicaid begins paying urban hospitals under a revised payment methodology effective July 1. The bulletin had a list of features of the new payment methodology. Item 5 should have read: "Separate payment adjustments for Graduate Medical Education and Disproportionate Share."

For information about the DRG payment methodology, contact Randy Baker, Associate Actuary, at (801) 538-6733. ☐

01 - 78 Transportation Broker for Van, Taxi Services

Beginning July 1, 2001, non-emergency medical transportation by van or taxi is handled by PickMeUp Medical Transport. Medicaid recipients qualifying for transportation must call 1-888-822-1048 for services. The criteria for qualifications to receive transportation services have not changed: (1) The transportation must be for a medical service. (2) The recipient does not have a vehicle nor access to public transportation. (3) Where public transportation is available, the recipient must be physically unable to ride public transportation, as certified by a physician.

The transportation broker will not handle requests for public bus passes or Flextrans. Those programs are not part of the brokered system. Administrative travel continues to be authorized by the eligibility workers.

Medical Transportation Manual Updated

Information on the transportation broker for van and taxi services is added to SECTION 2 as a new chapter 1 - 9, Transportation Broker for Van, Taxi Services. ☐

01 - 79 Transportation: 'Loaded Miles'; Non-emergency Transfers between Institutions; Out of State Non-emergency Transportation and Per Diem; Discontinued/Replacement Codes

This bulletin clarifies three policies regarding medical transportation: 'Loaded miles'; non-emergency transfers; and out of state non-emergency transportation between institutions. Policy for per diem is added. Certain codes have been replaced.

Loaded miles

Medicaid reimburses only for the transportation of qualified and eligible Medicaid recipients to and from medical appointments and services. Transportation is covered for "loaded miles" only, meaning "with the recipient on board." Miles driven to or from the place where the recipient is picked up are "unloaded miles." Mileage without the recipient on board is not reimbursable. This clarification is added to the Utah Medicaid Provider Manual for Medical Transportation Services, SECTION 2, Chapter 2, Covered Transportation Services.

Non-emergency Transfers between Institutions

Chapter 4 - 2, Hospital-to-Hospital Transfers, item 1 is revised to clarify the criteria for approval of non-emergency transfers between institutions.

1. The transfer must be medically necessary; and
2. The original hospital must have discharged the client; and
3. The criteria listed below must also be met.
   A. The necessary services cannot be obtained at the initial admitting hospital and the transfer is determined to be to the nearest hospital with facilities for appropriate care. This includes both in-state and out-of-state hospitals.
   B. When a patient is transferred between two hospitals for continuing treatment (the patient remains at Hospital A and is transferred daily to Hospital B for treatment), the transfers are the responsibility of Hospital A. Medicaid will not cover such transfers.
   C. Medicaid does not cover transport from a hospital capable of treating the patient to another hospital because the patient and/or his or her family prefers a specific hospital or physician.
   D. If the recipient is assigned to an HMO, the HMO is responsible for transportation services

Medicaid will not approve transfers solely because of patient and/or family preference or convenience.

Billing Instructions

Chapter 4 - 4, Billing, is updated to delete the statement that Medicaid provides instructions for filing claims on a paper HCFA-1500 form. The filing standards for the HCFA-1500 Claim Form are available from the insurance commissioner and through the Utah Health Information Network (UHIN) web site: www.uhin.com. UHIN also provides the software required to bill electronically. Contact the Utah Health Information Network (UHIN) for instructions.

Out of State Non-emergency Transportation and Per Diem

Chapter 5 is renamed "Out of State Medical Transportation, Per Diem and Border Towns." Policy for approval of out of state non-emergency transportation is clarified. Policy for approval of a per diem is added. Criteria are described briefly in the paragraphs which follows. For complete information, refer to the updated Chapter 5 attached.

Out of State Transportation

Prior authorization is required for non-emergency transportation to and/or from medical services outside the State of Utah, even when the recipient has a referral for the health care service. Medicaid, in consultation with the physician and other medical professionals, decides the most appropriate access to care for the patient. Transportation must be medically necessary and for medical services which are not available within a reasonable distance within the state.

Per Diem

If out of state transportation is approved and an overnight stay is required outside of a medical facility while receiving Medicaid covered medical services, a per diem to be applied toward the cost of meals and lodging may also be authorized. Criteria in Chapter 5 cover travel and per diem for a parent or attendant. Per diem payments shall not exceed a maximum established by the State.

Discontinued and Replacement Codes

SECTION 2, Chapter 7 - 5, (page 22) has a list of ambulance codes. Below are four new codes effective for dates of service on or after April 1, 2001. These replace discontinued codes which cannot be used as of April 1.

A0430, Ambulance Service, conventional, air service, transport, one way (Fixed Wing). Replaces discontinued code A0030, Air Ambulance service.

A0431, Ambulance Service, conventional, air service, transport, one way (Rotary Wing). Replaces discontinued code A0040, Helicopter ambulance service.

A0429 Ambulance service, basic life support, emergency transport (BLS-emergency). Replaces discontinued code A0362, Ambulance Services, BLS, emergency transportation.

A0425, Ground mileage per statute mile. Replaces discontinued code A0380, BLS Mileage.

SECTION 2, Chapter 7 - 3, Specialized Van Service Codes, (page 20) is updated to remove code Y1161, stretcher, vans. As announced in the October 1999 issue of the Medicaid Information Bulletin, this code could not be billed for services on or after October 1, 1999.

Medical Transportation Manual Updated

Transportation providers will find attached pages to update SECTION 2 of the Utah Medicaid Provider Manual for Medical Transportation Services. A vertical line in the left margin marks where text has changed. An asterisk (*) in the margin marks where text was deleted. ☐

01 - 80 Medicaid Interpretive Service Contract Added: Language Line Services

Medicaid has added another contractor, Language Line Services, to provide foreign language interpretation for Medicaid clients. Language Line Services, one of the nation's largest phone-based interpretive service providers, covers almost 200 languages. Their toll-free number, 1-800-874-9426, is available 24 hours a day, seven days a week, 365 days a year. Languages services will be charged to Medicaid, provided the conditions for coverage are met. The billing (contract) number is 546017.

For current information on all interpretive service contractors, including Language Line Services, check the Medicaid web site www.health.state.ut.us/medicaid/interpreter.pdf . You may also call Medicaid Information for policy, procedures, and information. ☐

01 - 81 Laboratory Services: CLIA Requirements

The CLIA list is updated for July 2001. Providers will find a copy attached to update the Utah Medicaid Provider Manuals for Physician Services and Laboratory Services. Codes are added to the columns titled "Certificate of Waiver" and "Codes Excluded from CLIA Requirements" and the list of CLIA Waiver Kits. Codes newly added are marked with an asterisk (*).

The updated list is also available on the Internet at www.health.state.ut.us/medicaid/clia.pdf. ☐

01 - 82 Electronic Copies of Medicaid Information Bulletins and Index

Medicaid Bulletins published since April 1997 are on the Internet. You can find the links to both the current and past bulletins at: www.health.state.ut.us/medicaid/html/provider.html .

There is also an Index to Medicaid Information Bulletins on the Internet. The Index has two parts: an alphabetical list of articles by keywords and title and a chronological list of bulletins by date published. The Index is at: www.health.state.ut.us/medicaid/IndexMIBs.pdf . ☐

01 - 83 Home Health: "Support from Family Care Givers" Defined, Clarified

The Utah Medicaid Provider Manual for Home Health Services has been updated to define the term "support from family care givers" and clarify its meaning. The following definition is added to SECTION 2, page 6: "**Support from family care givers:** means the act or an instance when a member of the family provides help or assistance to another family member who has permanent limitations or significant disability due to illness or injury. Support may be indirect such as visiting, shopping, running errands, doing laundry, preparing a meal. Support may also be direct hands on physical care within the ability of nonprofessionals to meet medical needs or support activities of daily living. Such support is not reimbursable to family members."

The following paragraph is added to SECTION 2, Chapter 1, General Policy, (page 2): "Home Health Agencies requesting services should encourage and identify how much help is available from the family to supplement the agency assistance. There is no age limitation for home health care. Support and assistance from family members is essential in order to maintain home health service for some clients at a level that is realistically appropriate and cost effective. Family members who have physical and/or medical limitations which could affect their ability to participate in supplementing agency services can provide a statement from their primary care physician identifying the limitations. The medical statement(s) will be considered in the evaluation of care needs."

Language is removed from Chapter 6, Home Health Procedure Codes, the criteria for Supportive Maintenance - Home Health Aide (page 29). The sentence deleted is "Approve only if there is no other care giver in the home or if the care giver is unable to provide care due to the care giver's physical limitations."

Home Health Manual Updated

Home Health agencies will find attached pages to update SECTION 2 of their manual. A vertical line in the left margin marks where text was added or changed. An asterisk (*) in the margin marks where text was deleted. ☐

01 - 84 Targeted Case Management Services for Early Childhood Development for Medicaid Eligible Children

A new Medicaid Provider Manual has been issued for early childhood development services for children born to women enrolled in Medicaid. Providers who qualify to render services will receive the manual. Other providers who are interested in the policy may contact Medicaid Information; ask for the manual called Targeted Case Management for Early Childhood Development for Medicaid Eligible Children. You may use a Publication Request Form or contact Medicaid Information.

The program enhances Medicaid services by providing targeted case management for children born to women enrolled in Medicaid. Participation is voluntary. Services begin when a qualified provider visits the home of a Medicaid newborn to complete an initial assessment. Information gathered during the assessment will assist providers in determining the needs of the newborn. Needs may range from minimal to intensive and may require referrals for needed services. Local community resources will be used when available. Referrals will be based on individual program criteria and restrictions. On-going case management activities may be provided for the targeted newborn based on the initial assessment.

Two important elements of the program are the establishment of a medical home and a collaborative relationship between the primary care provider and targeted care manager. Medical home refers to the collaborative effort between a primary care provider, children and their families to ensure that care is accessible, family-centered, continuous, comprehensive, convenient, compassionate and culturally competent. Results of the assessment, referral information and progress notes may be shared with the primary care provider to facilitate this arrangement.

Qualified providers are nurses employed by or contracted with local or district health departments to deliver services in accordance with the requirements of this manual and applicable Medicaid regulations. ☐

01 - 85 Smoking Cessation Services for Pregnant Women

Pregnant women enrolled in Medicaid may receive smoking cessation services including social support, skills training in problem solving techniques and access to pharmacological aids if recommended by their physician.

Extent of the Problem

According to the American College of Obstetrics and Gynecology, infant and fetal deaths could be reduced by as much as 10% by eliminating smoking among pregnant women[1]. With funds provided by the Tobacco Master Settlement Agreement, Medicaid is providing cessation services to their pregnant clients who use tobacco. This article briefly describes the extent of prenatal smoking by mothers in Utah, explains the Medicaid-funded cessation programs, and describes the potential impact of health care providers' advice to clients during and after pregnancy.

Experts estimate that 19 - 30% of women smoke during pregnancy[1]. Only about 20% of women quit smoking on their own while pregnant, and most resume smoking after giving birth[2]. Smoking rates among pregnant women in Utah are lower than the national rate. Although smoking rates for this population are low, over 20,000 Utah women smoked during pregnancy during the years 1993 through 1998. More than 5,000 of these were teens[2].

Medicaid Services for Pregnant Women

Women smoke for various reasons including weight control, stress management, depression, and nicotine addiction[3]. Pregnant women need programs to address their special needs. The programs funded by Medicaid are designed to meet their needs in the following ways:

- Offer support to help pregnant women quit smoking.
- Focus on lifestyle, weight gain, and the social and emotional issues facing pregnant women.
- Teach strategies to help pregnant women quit smoking for life.
- Provide pharmacological aids when appropriate.

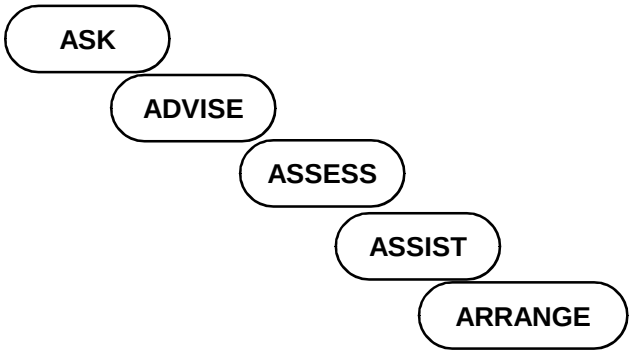
Medicaid has approved three smoking cessation programs which have demonstrated programs tailored to meet the special needs of the pregnant woman. These programs are in: the Salt Lake Valley Health Department, the Southwest Utah Health Department and the Tooele County Health Department. For women who would like to quit, but there is no program in the woman's local area, Medicaid has purchased a self help guide written for pregnant women. Medicaid staff will offer follow-up telephone calls to women using the self-help guide.

Influence of Provider Counseling

Health care providers are extremely influential in promoting smoking cessation. Each year, 1.7 million more smokers would quit if a health care provider advised them to do so. Pregnant women say that prenatal visits are an ideal time for smoking cessation advice[4]. Research confirms that almost 20% of pregnant women quit smoking after one 5 to 15 minute counseling session during pregnancy by a trained provider with appropriate printed materials [5]. This is nearly double the normal cessation rates of 5 - 10% without counseling.

5 A's of Smoking Cessation

The Public Health Service recommends that health care providers use the following **5 A's** as a brief intervention during an office visit by a tobacco user[6].



ASK
Many pregnant women deny smoking, and a multiple-choice question format improves disclosure [7] . For example: "Which of the following statements best describe your cigarette smoking?"

- I smoke regularly now, about the same as before finding out I was pregnant.
- I smoke regularly now, but I've cut down since I found out I was pregnant.
- I smoke once in a while.
- I have quit smoking since finding out I was pregnant.
- I wasn't smoking around the time I found out I was pregnant, and I don't currently smoke cigarettes.

ADVISE
In a clear, strong, and personalized manner, urge every tobacco user to quit.

- Clear - "I think it is important for you to quit smoking now, and I can help you."
- Strong - "As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect you and your baby's health now and in the future."
- Personalized - Tie tobacco use to current health/illness, and/or its social and economic costs, motivation level, and/or impact of tobacco use on their baby and others in the house.

ASSESS willingness to try to quit.

Which of the following statements best describes how you feel about smoking now?

- I am not ready to stop smoking.
- I'll be ready to stop smoking soon.
- I am ready to stop smoking now.
- I quit smoking.
- I quit smoking, but now have started again.

ASSIST patients who are willing to try to quit by using counseling and pharmacotherapy.

- Inform your pregnant patients enrolled in Medicaid about the cessation services available to them.
- Services include counseling/support programs and, with a prescription, nicotine replacement therapies.

  "Pharmacotherapy should be considered when a pregnant woman is otherwise unable to quit, and when the likelihood of quitting, with its potential benefits, outweighs the risks of the pharmacotherapy and potential continued smoking[6]."
- Expectant mothers in their teens can call the Teen Quit Line, 1-888-567-TRUTH (1-888-567-8788). For more information about this resource, refer to bulletin 01 - 04, Utah Teen Tobacco Quit Line: Telephone-based Resource for Teenagers(available on-line at www.health.state.ut.us/medicaid/january2001.pdf

ARRANGE follow-up.

When you help a pregnant patient enrolled in Medicaid with cessation services, Medicaid staff will follow-up with the woman to verify participation in the program. This follow-up, as well as your follow-up at the patient's next visit, provides additional support to the woman in her effort to quit smoking. You may notify the Medicaid program that your patient needs follow up by calling, or e-mailing, the program coordinator listed below.

Preventing Relapse

Preventing relapse is especially important for pregnant women because 70 percent begin smoking again within the first year after giving birth[8]. Having a partner or friends who smoke is a predictor for returning to smoking. Encourage patients to have a plan for coping with friends who smoke. If a lapse occurs, remind patients that it takes most people two to eight quit attempts to stop smoking for good. A lapse is often part of the smoking cessation process.

Your Support and Ours

Medicaid staff are committed to contacting new Medicaid enrollees who are pregnant and use tobacco to help them enroll in a cessation program. The Utah Department of Health, including the Medicaid Program, have ads airing on radio and TV to promote the Teen Quit Line as part of the "Truth About Tobacco" media campaign. We have also run adds targeting pregnant women. Your support to raise awareness of cessation services will help more mothers quit using tobacco. The most important step your patients can take to improve their health and the health of their baby is to stop using tobacco.

For more information on the Medicaid program to help pregnant women quit smoking, contact Julie Olson at (801) 538 -6303 or jolson@doh.state.ut.us .

References

Portions of this article are taken, with permission, from Dr. T. Lewis' article from the Utah Medical Association Bulletin, February 2000, Vol. 48, No. 2

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01 - 86 Client Information and Education

Articles sent to Medicaid clients in the quarterly newsletter "Clientell" are published on the Internet. Copies may be printed and freely distributed for nonprofit, educational purposes. An index of articles is at: www.health.state.ut.us/medicaid/html/clientell_index.htm

Below is a list of "Clientell" articles sent recently to Medicaid clients. If you don't know about Medicaid's monthly newsletter, there is more information at the end of this bulletin.

May 2001

- Utah Issues Conference (May 11): Community Solutions 2001
- Choosing and Using an HMO
- Seven Warning Signs of Cancer
- Fee for Services Clients: Speak Up For Yourself
- Hotline Resources in the Utah Department of Health: Check Your Health, Medicaid Information, Baby Your Baby, CHIP, Immunize by Two, Baby Watch Program, Utah Teen Tobacco Quit Line, Family Dental Plan.

Medicaid Client Newsletter "Clientell"

The "Clientell" is a quarterly publication by the Division of Health Care Financing which is mailed to all households receiving a Medicaid card. The purpose is to educate and inform clients of Medicaid policies, procedures and other issues. It is also a tool to share community resources.

The Utah Medicaid population is a very diverse group of people. Our goals are to make information easily understood and to be sensitive to literacy barriers and cultural differences in this population.

We welcome suggestions for articles from providers and other interested parties. The editor of the "Clientell" is Randa Pickle, Consumer Advocate for the Division of Health Care Financing. Please call 1-877-291-5583 or e-mail suggestions to rpickle@doh.state.ut.us. ☐

01 - 87 Mental Health Providers: Policy Clarifications

Effective July 1, 2001, the Utah Medicaid Provider Manual for Mental Health Centers and the Utah Medicaid Provider Manual for Diagnostic and Rehabilitative Mental Health Services by DHS Contractors have been revised to clarify the responsibility of licensed mental health therapists in the provision of mental health evaluations, the development of clinical treatment plans and the 180 day reviews of the clinical treatment plans.

The manuals have also been updated to clarify services certified social workers may provide, limitations to group skills development services, and the need for marriage and family therapist interns, psychology residents and professional counselor interns to hold a valid certificate from the Division of Occupational Licensing (DOPL) in order to provide mental health therapy services.

Also, in Chapter 2 - 2, Psychological Testing, the section on qualified providers has been revised. Previously, qualifications were more restrictive than state law requires. Last, Chapter 7 of the manual for Mental Health Centers now specifies that billing modifiers are only required when services are provided in a tele-health setting.

Providers will find attached SECTION 2 to update their manuals. A vertical line in the left margin marks where text was added or changed. An asterisk (*) in the margin marks where text was deleted. ☐

01 - 88 Long Term Care Payment: Adoption of a Severity or Case Mix Based Payment System

Medicaid will change the method of payment for a long term care facility effective for services delivered on or after October 1, 2001. The change will incorporate a "case mix" for each facility based upon the severity of illness of the patients, as measured by the Resource Utilization Groups (RUG) system. The RUG system was developed for the Medicare program and utilizes the Minimum Data Set (MDS) to generate the applicable RUG. The MDS data is submitted by the provider to the State, and simultaneously the provider generates the RUGs code by processing this data through the "Grouper" program. The payments for the system are currently being developed and will be distributed once approved. ☐

01 - 89 Substance Abuse Treatment Services: Policy Clarifications

Effective July 1, 2001, the Utah Medicaid Provider Manual for Substance Abuse Treatment Services has been revised to clarify the responsibility of licensed mental health therapists in the provision of mental health evaluations, the development of clinical treatment plans and the 180 day reviews of the clinical treatment plans.

The manual has also been updated to clarify services that licensed substance abuse counselors and certified social workers may provide, limitations to group skills development services, and the need for marriage and family therapist interns, psychology residents and professional counselor interns to hold a valid certificate from the Division of Occupational and Professional Licensing (DOPL) in order to provide services. Also, in Chapter 2 - 2, Psychological Testing, the section on qualified providers has been revised. Previously, qualifications were more restrictive than state law requires. In Chapter 7, references to billing modifiers have been deleted. Modifiers are not required on Medicaid claims.

Also effective July 1, 2001, Chapters 4 - 2 and 4 - 3, Targeted Case Management for Substance Abuse, have been updated to clarify eligibility for targeted case management services and necessary provider qualifications.

Providers will find attached SECTION 2, pages 1 - 19 to update their manuals. A vertical line in the left margin marks where text was added or changed. An asterisk (*) in the margin marks where text was deleted. ☐

01 - 90 Physician CPT Coding: Professional and Technical Components

Approximately 15 percent of CPT codes in the Medicaid Fee Schedule have a professional component and a technical component. The technical component applies to the conducting of a test, whereas the professional component applies to the interpretation of the test. This is most often the case in radiological procedures and other testing procedures. When a provider performs both aspects of the procedure, the code must be billed on two lines, once with a "26" modifier. If a code has two components and is listed only once without the modifier, payment will be made only for the technical component. Unlike Medicare, Medicaid does not have a global payment for these codes.

Fee Schedule

To determine whether a code has two components, one can consult the Medicare fee schedule to see if a 26 modifier is listed. One can also consult the Medicaid Fee Schedule under type of service "P" to see if the applicable code is listed. A copy of the Medicaid Fee Schedule is available for downloading on the web at: http://www.health.state.ut.us/medicaid/st_plan/bcrp.htm Note “st_plan” in the above address; “st plan” does not work. The fee schedule will be updated by July 1. You can also call Blaine Goff, 801-538-6440, to obtain a copy. ☐

01 - 91 Digital Hearing Aids

Beginning July 1, 2001, digital hearing aids (which do not include digitally programable hearing aids) are covered with telephone prior authorization. Children age six and under must meet the criteria for regular hearing aids. If over age six, the client must meet the criteria for regular hearing aids and have a language age less than six years as measured by standard tests, such as Receptive One Word Picture Vocabulary Test. Use code Y5135, digital hearing aids, single ear, to bill a digital hearing aid. Two units may be authorized for binaural applications.

Audiology, Medical Supplies Manuals Updated

Policy and a code for a digital hearing aid have been added to SECTION 2 of the Utah Medicaid Provider Manual for Audiology Services and to the Medical Supplies List. The list is part of two Utah Medicaid Provider Manuals: Physician Services and Medical Suppliers.

Audiologists will find attached pages 1 and 8 through 11 to update SECTION 2. A new chapter 5 - 3, Additional Criteria for Digital Hearing Aids, is added. Code Y5135, digital hearing aid, is added to Chapter 6, Procedure Codes. A vertical line is placed in the margin next to text which was added. The code newly added is in bold print.

Physicians and medical suppliers will find attached page 57 - 58 to update the Medical Supplies List. The code Y5135, digital hearing aids, is in bold print on page 58. ☐